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Williams, Simon J.

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Parsons revisited: from the sick role to . . . ?

Simon J. Williams

University of Warwick, UK

ABSTRACT This article revisits Parsons' insights on medicine, health and illness in the light of contemporary debates in medical sociology and beyond. A preliminary balance sheet of the Parsonian legacy is first provided, taking on board standard accounts and criticisms of Parsons' work within medical sociology to date. The remainder of the article, in contrast, involves a close re-reading of Parsons in the light of contemporary sociological debates on the body, emotion, trust, uncertainty and health, including late modern and postmodern interpretations of his work. Parsons, it is concluded, despite his (many) critics and detractors, has much to contribute here, not simply in terms of past insights, but also with regard to the present and future.

KEYWORDS *body; emotion; health; Parsons; trust, uncertainty*

ADDRESS Simon J. Williams, Department of Sociology, University of Warwick, Coventry, CV4 7AL, UK. [e-mail: s.j.williams@warwick.ac.uk]

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Introduction

It is, by now, a well-rehearsed argument that Parsons is a key figure, if not a 'founding father', as far as the origin and development of medical sociology is concerned. Parsons' analysis of illness as social deviance, and the sick role as a socially prescribed mechanism for channelling and controlling this deviance, is a key point of reference in the history of medical sociology, and a staple part of the diet that students of medical sociology (or sociology of health and illness as it is now more commonly known)¹ are fed, year in year out, on both sides of the Atlantic. So extensive have these discussions of Parsons been, and so familiar the lines of criticism advanced, that we may justifiably feel fed up or sick of the sick role, believing that we are now (thankfully) much further forward in these debates, as the sociology of health and illness finds its feet, and the pace of social change increases.

Is Parsons, then, a relic of the dim and distant past, as far as current agendas in the sociology of health and illness are concerned? Is there, in

other words, any merit in revisiting, once again, these Parsonian insights in the light of contemporary debates in the sociology of health and illness and beyond? Can we bear it? There is, I believe, in answer to these questions, much to be had from a return to, revisiting or revival of interest in Parsons' insights in this domain, not least in terms of *contemporary* debates within the sociology of health and illness and beyond. Herein lies the rationale for this article, which returns to and re-reads Parsons in and through the following contemporary sociological themes and issues: the body, emotions, trust, uncertainty and health. Doing so, I venture, provides the means for a profitable and productive dialogue or interchange between past and present sociological concerns and insights that in turn flags future potential agendas.

Before doing so, however, a brief reprisal or preliminary balance sheet of the main lines of debate concerning Parsons' contribution to medical sociology if not the sociology of health and illness may prove useful as a backdrop to the themes and issues that follow. What, that is to say, according to standard accounts and conventional wisdom, are we to make of the Parsonian legacy for medical sociology?

The Parsonian legacy: a preliminary balance sheet

The usual line or gloss on Parsons, taking Chapter X of *The social system* (Parsons, 1951) as its point of reference, runs something like this. Parsons, in keeping with his structural-functionalist principles, viewed health as a functional prerequisite of society. From the point of view of the social system, too low a level of health and too high an incidence of illness is dysfunctional. Illness, in other words, given its interference with normal role capacity, becomes a form of social deviance that needs channelling therefore in an appropriate fashion through an institutionalized role or niche.

The sick role, for Parsons, fulfils precisely these goals through a series of rights and obligations that its incumbents must recognize and respect. On the rights side of the equation, the patient (according to the severity of the illness) is exempt from normal role obligations, and is not deemed responsible for falling ill. On the obligations side of the equation, the patient must seek technically competent help and must want to get well. The doctor, for his part (Parsons, a product of his times, always refers to men),² must apply these technically competent skills in order to facilitate (a swift) recovery, guided as he is by the professional constellation of achievement, universalism, functional specificity, affective neutrality and collectivity-orientation (i.e. Parsons' (in)famous pattern variable schema).³

The sick role, therefore, serves to discourage the secondary gains of illness and prevent what Parsons, rightly or wrongly, sees as a deviant subculture of sickness from forming through this reciprocal cluster of rights and obligations, the aim of which is to reintegrate the individual back into society through a return to normal role capacity (or an approximation thereof) as quickly as possible.⁴

The merits of this Parsonian analysis, as noted in the introduction, have been much debated over the years, both theoretically and empirically. The main lines of criticism, in this respect, concern Parsons' *consensual* (medico-centric) approach to these matters; his formulation of what in effect is a *patient* role which neglects the illness iceberg; the limited applicability of the sick role to *chronic illness* and other conditions such as pregnancy; and his failure to address factors such as *class*, *gender*, *age* and *ethnicity* in medical encounters. We may also question whether illness is deviance, given (1) the extent of illness in the community and (2) the fact that sick role incumbency involves *conformity* rather than deviance (Pflanz and Rhode, 1970) – for classic sociological critiques and extensions to the Parsonian sick role see, for example, Gallagher (1976) and Freidson (1970); see also Freund et al. (2003) for a more recent critique. These, to be sure, are important points to raise and cannot be dismissed lightly. Nor is it my intention to do so. In response to his critics, none the less, Parsons (1975) claimed that: (1) he had never meant to confine the category of illness to deviant behaviour, though its negative valuations should nevertheless be borne in mind; (2) his concerns were not exclusive to cases of acute illness as opposed to chronic illness; and (3) although interaction between doctor and patient is a two-way not one-way process, it is still basically asymmetrical because of the physician's expertise and the special fiduciary responsibility this entails for the care of the sick (of which more later).

Abiding themes/contemporary insights: connecting past and present

Whether or not Parsons was successful here in revisiting or defending the sick role is, of course, a moot point. The above criticisms, to repeat, cannot be dispensed or done away with easily. There is none the less, I contend, much to be gained from a close re-reading of Parsons in the light of contemporary themes and debates within and beyond the sociology of health and illness. Five key themes and issues, in particular, themselves far from exclusive or exhaustive, merit further discussion in this context.

The (sick/mortal) body: the sacred and the profane

There has, to be sure, been an explosion of interest in the body in recent years debates, which seem to take us far beyond anything remotely Parsonian (Turner, 1984; Shilling, 1993; Nettleton and Watson, 1998; Williams and Bendelow, 1998; Williams, 2003). This may well be true, but there are also rich Parsonian themes to mine here, as contribution to these more recent debates.

Perhaps the first thing to say in this respect, given the dominance of social constructionist perspectives (on the body and disease), is that Parsons, unlike many (medical) sociologists, not only had a long-standing interest in biology, but a preliminary training in medicine; credentials which,

without over-stretching the case, imbued his analysis with a certain realist tone or quality as far as the ontological vulnerability of corporeal bodies and the potential for human suffering are concerned. Illness, in other words, is not solely or simply a social state of affairs, however important these social factors might be.⁵ As Parsons puts it, in his own inimitable fashion:

Illness is a state of disturbance in the 'normal' functioning of the total human individual, *including both the states of the organism as a biological system and of his personal and social adjustments*. It is thus *partly biological and partly socially defined*. Participation in the social system is always potentially relevant to the state of illness, to its etiology and to the conditions of successful therapy, as well as other things. (1951: 431, emphases added)

Illnesses, Parsons stresses, range from the 'purely somatic' to the 'purely mental', both of which are 'limiting concepts' with the prominence of the factors of 'relativity' due to 'culture and social structure' increasing as one progresses along this continuum (1964: 258). The importance of the 'inter-penetration' between somatic and mental aspects is 'so great', however, that it would be 'a mistake', in Parsons' view, to 'draw any rigid line, in any empirical terms, between them' (1964: 258). Issues of urgency and severity, of course, complicate the picture further here, but Parsons is clear that pain, suffering and the risk of death, or serious, lengthy or permanent disablement, singly or in combination, are common features of what it is to be sick, thereby suggesting if not demanding the need for technically competent help. 'Feelings of helplessness' and the 'need for help', that is to say, are 'very real' (1951: 440). The dilemmas of the sick, in short, given the (ontological) contingencies and vulnerabilities of *both* psyche and soma, bring person qua patient and expert qua doctor into an existentially charged situation that requires careful management on both sides.

Matters do not end here, however, as far as Parsons' treatment of the body is concerned. The physician deals with 'human beings', he declares, and does so in situations which often involve 'intimacies' and which are often 'peculiarly "private" to the individual, or to especially intimate relations with others' (1951: 451). The 'integrity of the individual' and the "inviolability" of the body', therefore, weigh heavily in the balance sheet as far a medical practice is concerned. The amounts and occasions of bodily exposure and contact, indeed, are 'carefully regulated in all societies, especially ours'. To see a person naked, in this context, where this is not usual, is a 'privilege' which calls for explanation in view of these factors, particularly when exposure and contact involves a patient of the opposite sex – although physical contact between men, and between women, is also closely regulated. Both the 'parts of the body themselves' and 'acts of exposure and of bodily contact', from this Parsonian viewpoint, are 'expressive symbols of highly strategic significance', in or out of the doctor's surgery (1951: 451).

Along with this goes the related problem of sentiments towards injury of the body, which include issues such as anxiety about the insertion of

needles, and the problem of seeking consent to surgical procedures and many types of diagnostic tests: none of which, Parsons insists, can be taken for granted (1951: 452). Similar considerations apply to the physician's need of access to confidential information about the patient's private life. Successful control, in this respect, given the '*potentialities of disturbance*', presents 'peculiarly important sociological problems' (1951: 452, emphasis in original).

To these Parsonian dilemmas of living bodies, we may add his insights into the medical rites and rituals associated with dead bodies. It is striking, Parsons notes, that medicine is one of the few occupational groups which in our society have 'regular, expected contact with death in the course of their occupational roles'; the clergyman, the undertaker and in certain ways the police being the other principal ones (1951: 444). This association with death, Parsons ventures, is a very important factor, not simply in the 'emotional toning' of the role of the physician, but also in terms of issues to do with the sacred. The dissection of a cadaver in medical training, for example, is something of a 'solemn ritual' or rite of passage, which medical students often have quite violent emotional reactions to, especially the first day. It may therefore be concluded that:

dissection is not only an instrumental means to learning anatomy, but is a symbolic act, highly charged with affective significance. It is in a sense the initiatory rite of the physician-to-be into his intimate associations with death and the dead. (1951: 445)

Whether, of course, the advent of 'virtual dissection' and 'cyber-anatomy', realized through on-line developments such as the virtual human project (Waldby, 2000), radically changes these associations, reactions and relations is a moot point. Confrontations with the mortal body, if not the cadaver, none the less, are an inescapable part of medical practice, both as neophyte medical students and fully fledged physicians.

As for broader questions of death in the western world, particularly the frequent allegation of 'death denial', Parsons' answer is unequivocal:

death, or the limited temporal duration of the individual life course, must be regarded as one of the facts of life that is as inexorable as the need to eat and breathe in order to live. In this sense, death is completely normal, to the point that its 'denial' must be regarded as pathological. Moreover, this normality includes the consideration that, from an evolutionary point of view . . . death must be regarded as having high survival value, organically at least to the species, actionwise to the future of the sociocultural system. These scientific considerations are not trivial, or conventional, or culture-bound but are *fundamental*. (1978a: 346, emphasis in original)

This, however, he hastens to add, in keeping with the foregoing analysis, should not be taken to imply that death is now met with calmness or equanimity. On the contrary, anxiety about death, both that of others and that of one's own, is still very much in evidence, even if death itself is not denied

or disavowed. In certain circumstances, indeed, Parsons ventures, 'the level of anxiety may be expected to increase rather than the reverse' (1978a: 349).

Parsons' approach to the (sick/mortal) body, then, as this brief sketch suggests, is rich and multifarious, including the existential predicaments and dysfunctional consequences of sickness, the expressive symbolism and strategic significance of bodily exposure and contact and related issues of intimacy and taboo, life and death, if not the sacred and the profane. The Parsonian patient, we might say, dead or alive, is far from disembodied.

This in turn paves the way for a related set of musings concerning Parsons' insights into the emotional and psychodynamic elements of the medical encounter: issues, as we shall see, which throw the limits of consumer reflexivity and associated rhetoric concerning contemporary health care into critical relief.

Emotion, reflexivity and the unconscious: the return of the repressed?

As with the body, sociological attention to the emotional dimensions and dynamics of social life has mushroomed in recent years (James and Gabe, 1996; Bendelow and Williams, 1998; Williams, 2001). Again, without wishing to push the case too far, Parsons' insights foreshadow much of this current debate, particularly as far as the nature and dynamics of the medical encounter, both past and present, is concerned.

The situation of illness, Parsons notes, building on the foregoing (bodily) insights, presents the patient and those close to him with complex problems of 'emotional adjustment'. This is, to put it bluntly, a situation of 'considerable strain'. Even if there is no question of a 'psychic' factor in the condition in question:

Suffering, helplessness, disablement and risk of death, or sometimes its certainty, constitute fundamental disturbances of the expectations by which [we] live. They cannot in general be emotionally 'accepted' without the accompaniments of strain with which we are familiar and hence without difficult adjustments unless the patient happens to find *positive satisfactions* in them, in which case there is also a social problem. The significance of this emotional factor is magnified and complicated in so far as defensive adjustive mechanisms are deeply involved in the pathological condition itself. (Parsons, 1951: 443)

More specifically, Parsons stresses, two types of reaction on the part of the patient may be prominent here: first a kind of emotional 'shock' at the beginning of illness, and second 'anxiety' about the future. The tendency to over-estimate the chances of a quick and complete recovery is also noted by Parsons, thus making even the necessary degree of emotional acceptance of the reality of the situation difficult. Alternatively, 'exaggerated self-pity' and 'whining' may occur, which itself, we might comment, has as much to do with the social setting the patient finds themselves in as it does with the particular emotional characteristics and dispositions of the patient in

question. What physicians do, moreover, 'inevitably influences the emotional states of the patient, and often this may have a most important influence on the state of their cases' (1951: 443).

All in all, then, without even considering the emotional stresses and strains of the physician's role, this amounts to a highly charged, or potentially highly charged, situation, which in Parsons' terms, makes a high level of 'rationality of judgement peculiarly difficult' for the patient; or to put it another way, leaves the patient 'open to, and peculiarly liable to, a whole series of ir- and non-rational beliefs and practices' (1951: 446).

We may well wish to take issue with Parsons here, not simply in terms of his characterization of the 'irrational' patient, but in terms of his problematic equation of emotion with these ir- or non-rational dimensions of life; a common problem, in fact, not simply confined to Parsons (Williams, 2001).⁶ The basic fact holds, none the less, that the emotional dimensions of illness in general and the sick role in particular, are of no small importance or significance in medical practice and should not therefore be neglected.

Parsons, however, pushes these insights much further through his own interest and training in psychoanalysis. Perhaps the key issue here for our purposes, concerns the fact that the physician tends to acquire, through processes of a largely unconscious nature, various types of 'projective significance which may not be directly relevant to his specifically technical function' (1951: 453). These issues, in psychoanalytic parlance, are related to the 'transference' phenomenon, which derives from the psychological needs of the patient, who invests the physician with 'inappropriate' and unrealistic significance, not infrequently related to a reactivation of parental roles in childhood. Transference, Parsons states, is most conspicuously encountered in 'psychiatric cases', but there is 'every reason to believe that it is always a factor in the doctor/patient relationship, the more so the longer their duration and the greater the emotional importance of the health problem and hence the relation to the physician' (1951: 453). Taken together, these issues, in conjunction with the physician's own handling of the *counter-transference* phenomenon, present a 'very considerable set of complications' to the functioning of medical practice on the level of human adjustment: issues which the specific duties and obligation of these reciprocal role structures are designed to meet and overcome, both *latently* and *manifestly*.

In particular, the professional constellation of *achievement*, *universalism*, *functional specificity*, *affective neutrality* and *collectivity-orientation*, mentioned earlier, functions to ensure that a specific series of mechanisms are in place to meet these strains and overcome the obstacles to the 'effective practice of scientific medicine'. Not only does this enable the physician to 'penetrate' sufficiently into the private affairs of the patient, it effectively protects the former from being drawn into the transference relation: 'whether it is love or hate the patient projects upon him, he fails

to reciprocate in the expected terms. He remains objective and affectively neutral' (Parsons, 1951: 460–1).

This discrepancy between the transference reaction and the realistic role of the physician provides a crucial point of *therapeutic leverage*, not simply in psychotherapeutic settings, *but in medical contexts more generally*, whether one is aware of it or not. Psychotherapy to the 'militantly anti-psychiatric organic' physician, Parsons states:

is like theory to the anti-theoretical empirical scientist. In both cases *he practices it whether he knows it or wants to or not*. He may well indeed do it very effectively just as one can use language without even knowing it has a grammatical structure. But the general conclusion is that a *very important part of non- and pre-psychiatric medical practice is in fact 'unconscious psychotherapy'* and this could not be true if the institutional structure of the physician's role were not approximately what it has here been shown to be. (1951: 462, emphases added)

From this, returning to and elaborating upon the preliminary sketch of Parsons at the outset of this article, flows the following general conclusion. The sick role and physician role serve as mechanisms of 'social control' through the 'channelling' of deviance, in this case illness, thereby avoiding other (debatably) 'dangerous' possibilities, such as group formation (i.e. a 'deviant sub-culture' of the sick). The sick role, in other words, provides both an 'insulating' and 'reintegrative' function, the significance of which, as we have seen, is greatly enhanced through the *conscious and unconscious processes of psychotherapy* which, in a general sense, may be subsumed under the rubric of the '*art of medicine*'. All good medicine, to repeat, involves some degree of psychotherapy. Deliberate psychotherapy, however, is:

only the tip of the iceberg which extends above the water. *The considerably larger part is below the surface of the water*. Even its existence has been largely unknown to most psychiatrists, to say nothing of laymen. It consists in certain institutional features of the physician's role in its particular form of meshing with the sick role. (Parsons, 1951: 478, emphases added)

The sick role, in short, is part and parcel of a much larger set of mechanisms embedded in the social system: a 'window', effectively, on a broader set of motivational balances, of which illness is part, extending far beyond the doctor's surgery.

Gerhardt (1979, 1987, 1989) sheds further important light on these issues, delineating what she takes to be two models of illness in the Parsonian paradigm. The 'incapacity model', as she terms it, focuses on illness as a breakdown of role capacity, the aetiology of which are role-related strains due to competitive occupational and other roles, with therapy viewed in terms of the exemptions and duties of the sick role. The 'deviancy model', on the other hand, views illness as *motivated deviance* from the norm to conform with role expectations, the aetiology of which is related to repressed dependency needs which acts as *unconscious motivation* to becoming ill (through greater exposure to risks, for example, of accident, injury or

infection), with therapy conceived as a four-stage process of social control. 'Unconscious psychotherapy', within this latter model, moves from *permissiveness* to *support*, to *denial of reciprocity* (selective rewarding), to *manipulation of rewards* (reinforcement); a process in which unleashed dependency needs are re-repressed and superego controls restored *en route* to recovery (Gerhardt, 1979: 238). These two models therefore may be characterized as *structural* and *psychodynamic* explanations of illness respectively. They may be reconciled, Gerhardt suggests, by virtue of the fact that they focus on 'different stages of the illness process, and may be seen as complementary rather than alternative' (1979: 238). For Gerhardt, moreover, returning to the criticisms of Parsons at the beginning of this article, there has been a tendency to mistake the structural incapacity model for Parsons' deviance model of illness, thereby over-simplifying the paradigm and resulting in much misplaced criticism – see also Gerhardt (1987, 1989).

These emotional and psychodynamic issues, it is clear, are as relevant today as ever they were, not simply as far as developments in areas such as general practice are concerned – where patient subjectivity and the role of the doctor as 'friend, guide and counsellor' is increasingly stressed (see Armstrong, 1983, 1984; Gothill and Armstrong, 1999) – but also in terms of what they have to say about the limits of consumer reflexivity in health care. The underlying assumption of much consumerist *rhetoric* in health care, for example, as Lupton points out, is of a rational reflexive agent, or a dispassionate calculating subject, who is encouraged to: (1) resist paternalism or medical dominance; (2) actively evaluate health care sciences; (3) voice complaints through appropriate channels; and (4) 'shop around' (potentially at least) should the 'commodity' which health care is fast becoming not prove up to scratch (1997a: 373–4) – see also Henderson and Petersen (2002) for an exploration of the diverse meanings and manifestations of consumerism in health care.

Yet as Lupton found in her own empirical study, in a manner that echoes and amplifies these Parsonian insights, this privileged representation of the patient simply fails to recognize:

the often unconscious, unarticulated dependence that patients may have on doctors. This representation also tends to take up the mind/body separation in its valorizing of rational thought over affective and embodied response. It is as if 'the consumer' lacks the physically vulnerable, desiring, all-too-human body which is the primary object of medical care. (1997a: 380, emphasis added)

Herein lies the paradox that, far from assuaging anxiety, the imperatives of consumerism in health care may actually exacerbate it. Instead of alleviating the vulnerability and anxiety accompanying such dependence, that is to say, 'the continuing emphasis upon autonomy, individualism and distrust in consumerist discourse may only serve to generate further uncertainty and vulnerability' (Lupton, 1996: 170). Lay people, in short, may pursue both the ideal-type 'consumerist' and 'passive patient' subject positions

simultaneously or variously depending on the context in question. Either way, a one-sided emphasis on consumerism fails to account for the complexity of medical encounters and the changeable/chargeable nature of desires, emotions and needs contained therein (Lupton, 1997a).

As for broader questions concerning the merits or relevance of a psychoanalytically informed (medical) sociology, this itself has been the subject of recent (heated) discussion and debate. On the one hand, writers such as Figlio (1987) and Lupton (1997a), call for a medical sociology or sociology of health and illness which incorporates understandings of subjectivity derived from psychoanalytic writings, with particular reference to the medical consultation and illness experience. A sensitive and sympathetic return to Parsons – alongside other writers on the psychodynamics of the medical encounter such as Stein (1985) – is indeed appropriate on this count. Lupton (1997b) goes further in fact, arguing not only that Foucauldian thought reprises in many ways some of the themes of Parsonian thought (given a similar interest in the voluntary taking up of societal imperatives), but that there is much value in bringing together Foucauldian and theoretical psychoanalytical perspectives on subjectivity in ways that go beyond the therapeutic emphasis on the use of psychoanalysis in favour of a more critical approach. The contradictory nature of desires and imperatives, she rightly argues, is integral to the understanding of humans as social beings. It is important for current debates on the potential of human agency and resistance, therefore, including those arising from Foucauldian critiques, to recognize this:

contradiction and ambivalence at the heart of subjectivity and the potentially disruptive nature of desire and the unconscious. The psychoanalytic perspective goes some way to providing a theoretical basis for the emergence of resistance to social norms and expectations. *Individuals are viewed as actively participating in their own domination as well as resisting it, disrupting as well as conforming to convention because of emotional investments, desires and phantasies that they themselves may be unable fully to articulate.* (Lupton, 1997b: 576, emphasis added)

Without some degree of understanding of the psychoanalytic processes involved, Lupton contends, sociologists of health and medicine will be ‘unable fully to analyse the continuing complexities of the doctor/patient relationship, the medical encounter and the illness experience’ (1997b: 577). Psychoanalysis, moreover, not only provides potentially valuable insights into (Kleinian) processes such as *projection*, *introjection* and *splitting* (of the ‘good’/‘bad’ variety)⁷ by doctors and patients alike, it can also be turned on the sociological imagination itself in more or less fruitful or ‘playful’ ways (see Craib, 1988, 1995, 1997).

Caution is needed here, however, suggesting perhaps the need for a somewhat more *tempered* response to the sociological merits of psychoanalysis. Pilgrim (1998), for example, raises a number of important points here in his rejoinder to Lupton (1997b). Psychoanalysis, he notes, has

indeed had a 'fair airing' within social science, rather than sociology per se, throughout the 20th century. What is needed, therefore, is for psychoanalysis to be 'appraised not praised'. While the illuminating contribution of groups such as the Frankfurt school is important to acknowledge, the 'problems of psychoanalysis-as-social-science should also be critically estimated' (1998: 542). Of particular note in this respect is its 'doctor-centred authoritarianism' – psychoanalysis *itself* is a version of medical work – its imperialistic stance towards subjectivity, its lack of internal coherence and its tendency towards psychological reductionism; all of which, Pilgrim suggests, make it a 'rather dubious starting point for medical sociologists' (1998: 542). Viewed in these terms, alleged sociological neglect or ignorance of psychoanalytic matters (since Parsons' time) may not simply be well founded but a carefully considered stance.

What this boils down to then, in part at least, is a struggle between those advocates of a 'psychoanalytic sociology' and those, like Pilgrim, who instead favour a 'sociology of psychoanalysis' and a defence of the irreducible social and material dimensions of life. There may, however, be something of a middle ground here, which characterizations of this kind tend to gloss or miss. Sociologists, to be sure, should rightly be cautious or wary of too readily and uncritically endorsing or incorporating psychoanalytic ideas into their work, but this far from precludes or rules out the importance of psychoanalytic ideas and understandings within sociology. Lupton none the less, like others before her, is surely right to remind us of the importance of more critical approaches or rapprochements which recognize the complexities and contradictions, ambiguities and ambivalences of us all qua patients, people and social beings. There are, in short, limits to sociology, just as there are limits to psychoanalysis (see Craib, 1988) which itself, surely, demands or necessities an ongoing dialogue and debate, if not a rapprochement of sorts.

Authority, trust and expertise: old wine, new bottles?

It is at this very point that certain other key features of Parsons' account, already touched on or alluded to earlier, come to the fore; issues, that is to say, to do with authority, trust and expertise. We may very well, returning to some of the standard criticisms levelled at Parsons, question the *consensual* and *functionalist* assumptions upon which his portrayal of the doctor–patient relationship rests, particularly in the current era where more 'negotiative' if not 'conflictual' relationships are said to exist. The 'doc as daddy' bias is also, to repeat, inappropriate or wide of the mark.

Again, however, I venture, Parsons' underlying assumption and defence of the basically asymmetrical nature of the medical encounter, and the authority, trust and expertise upon which it rests, cannot be dismissed or discounted lightly. While acknowledging that interaction between physician and patient is *two-way* not one-way, Parsons (1975) indeed, as noted earlier, insists that the relationship is basically asymmetrical due to the physicians'

legitimate authority and expertise in matters of health and illness, gained through prolonged training and experience, and expressed through the special *fiduciary responsibility* for the care of the sick; an orientation, to repeat, based on achievement values, universalism, functional specificity, affective neutrality and collectivity-orientation, thereby contrasting sharply with competitive commercial relationships.

This in turn may be interpreted to mean that the relationship is expected to be one of “mutual trust”, of the belief that the physician is trying his best to help the patient and conversely that the patient is “cooperating” with him to the best of his ability’ (Parsons, 1951: 464). In a very special and informal sense then, Parsons argues, the doctor–patient relationship ‘has to be one involving an element of authority’, but one which is not legitimized without reciprocal collectivity-orientation in the relationship. To the ‘doctor’s obligation to use his authority “responsibly” in the interest of the patient’, in other words, corresponds the ‘patient’s obligation faithfully to accept the implication of the fact he is “Dr X’s patient” and *so long as this remains the case* must “do his part” in the common enterprise’ (1951: 465).

Two further points are worth stressing in this context. First, contra standard critiques, the patient is far from ‘passive’ in Parsons’ view. Acceptance of treatment itself, he insists, is one type of *active* participation of the sick person. The less acute the immediate situation, moreover, ‘the more likely it is that this participation will be substantial’, extending into ‘functionally different areas’, including active participation in research programmes (1975: 270). The second point meshes closely with the first, namely that lay people, Parsons is happy to acknowledge, as a consequence of their education and experience, ‘have a certain amount of knowledge and understanding in matters of health and illness’ (1975: 271). Again this proves a corrective, of sorts, to misplaced criticism that it is only doctors, in Parsons’ view, who have any real know-how when it comes to matters of health and illness. The notion of *technical expertise* and *specialized training*, none the less, he suggests, provides an important reminder, if not warning, of the limits of any such lay knowledge and understanding. Lay judgements in these matters, indeed, Parsons boldly proclaims, are ‘notoriously fallible’ (1975: 271).

This returns us, once again, to Parsons’ underlying conviction that the ‘professional–lay relationship in the field of illness and health care cannot be treated as a fully symmetrical relationship in the hierarchical dimension’. With respect to the ‘inherent functions of effective care and the amelioration of conditions of illness’, that is to say, ‘there must be a built-in insitutionalized superiority of the professional roles, grounded in responsibility, competence and occupational concern’ (1975: 271). This, Parsons hastens to add, is not for a moment to say that ‘the exact ways in which the lines should be drawn can be neatly deduced from such general considerations’. These matters, instead, are ‘inherently extremely

complex, and the situation is far from being static'. Hence, it is entirely reasonable to suppose that 'the lines should be shifted from time to time in the light of new knowledge and changing conditions' (1975: 272). Despite this, Parsons 'fails to see' how it is 'possible to eliminate the element of inequality' at the heart of the doctor-patient relationship (1975: 272).

Translated into contemporary debates on medical practice in particular and health care in general, two key issues arise here. The first concerns recent (policy) debates on the advent of so-called 'lay experts' and 'expert patients'. We see this, for example, very clearly in current sociological debates as to just how 'lay' lay beliefs are in fact (Shaw, 2002), the shift from notions of lay 'beliefs' to lay 'knowledge' (Good, 1994; Bury, 1997) and in recent Government initiatives such as *The expert patient: A new approach to chronic disease management for the 21st century*, published by the Department of Health in September 2001 – a key element of which was to introduce self-management training programmes (developed in the United States) for patients. Expert patients, this document boldly proclaims, 'feel confident' and 'in control' of their lives; aim to manage their condition and its treatment 'in partnership' with health care professionals; 'communicate effectively' with professionals and are 'willing to share responsibility and treatment'; are 'realistic about the impact of their disease' on themselves and their families; and finally 'use their skills and knowledge to lead full lives'.

There is, to be sure, much to criticize as well as commend in such documents and policy statements, not least as far as Government rhetoric and individual responsibility are concerned. A return to Parsons indeed provides a further note of caution here, not simply in terms of the limits to consumerism identified earlier, but more specifically in terms of the limits of lay people's own *technical competence and expertise* in medical matters. Yes, people may become experts of sorts, including participation in training programmes of this very kind perhaps, but what we are really talking about here, in the main, are experiential or embodied forms of knowledge, rather than technical expertise. This knowledge, moreover, echoing Parsons, may be 'factually incorrect', 'wide of the mark', 'in error', or 'downright dangerous', from a scientific or technical viewpoint at least. Prior (2003), it seems, is of a similar opinion, with data to back it up from his own recent research in this domain. Patients, he admits, 'can have extensive knowledge of their own lives and the conditions in which they live'. They can also, and sometimes have to, turn themselves into 'experts in order to challenge medical hegemony'. But, for the most part, he argues:

lay people are not experts. They are, for example, rarely skilled in matters of (medical) fact gathering, or in the business of diagnosis. What is more they can often be plain wrong about the causes, course and management of common forms of disease and illness. (2003: 45)

It is perhaps time to recognize then, Prior concludes:

the virtues of expertise, and not to confuse issues concerning the use and manipulation of technical knowledge (the realm of expertise) with the worthy political aim of ensuring participation and consultation of the lay public in all matters to do with medicine. (2003: 54)

There are dangers here too, of course, of downplaying or devaluing these other forms of (embodied, experiential) expertise, and of confusing or conflating lay knowledge with lay beliefs. The general point, none the less, holds good that there are problems as well as opportunities to any such 'levelling of the playing field' when it comes to matters of expertise.

The second key issue here concerns the fate of Parsonian 'trust' in contemporary medical practice. Trust relations may well have changed (since Parsons' time) in conditions of late or postmodernity; a shift, in Giddens' (1991) terms, towards more 'active' forms of trust that have to be continually won rather than assumed in the face of (radical) doubt. Yet trust, active or otherwise, remains a vital ingredient of all social relations, including our dealings with medicine and doctors. This indeed is very much the assumption behind recent attempts, on the part of the British medical profession, to (re)establish public trust through sound self-regulation which should, it is argued, bring the public's and the profession's interests 'successfully together' (again). A 'strengthened professionalism', in other words, demonstrating good standards of practice and effective mechanisms of self-regulation and openness, is the proposed 'remedy' for medicine's malaise: the means of (re)securing public trust while safeguarding, at one and the same time, the independence of the profession in the face of greater threats of external control (see, for example, Irvine, 1997a, 1997b, 2001; GMC, 2002) – some things never change!

To this, of course, we may add the further paradox, if paradox it is, that people's alleged increasing disillusionment with medicine goes hand in hand with our increasing dependence on it. Our trust or faith in medicine, in short, may well be different now than it was in Parsons' time, though even this is debatable, but it has far from disappeared altogether, even in these 'uncertain' times.

Uncertainty, magic and pseudo-science: the limits of rationalization?

These discussions of authority, trust and expertise, in turn raise important further questions as to the very nature and status of medical knowledge, and its application in the clinical context. More specifically, in the face of ongoing rationalization processes, if not the McDonaldization of medicine and health care (Turner, 1992; Ritzer, 1995, 1997), it forces us to confront inescapable elements of uncertainty, if not magic or pseudo-science, in medical practice, both past and present.

Again Parsons' analysis of medical practice provides a seminal contribution

to these debates; one actively taken up and pursued, as a lifelong project, by Parsons' protégé Renee Fox (whose work we shall return to shortly). It has already been said that, for Parsons, there are many potential or inherent sources of (emotional) strain, tension and frustration in medical practice, which themselves acquire special significance because of the 'magnitude' and 'character' of the 'interests at stake' (Parsons, 1951: 449). The absolute limits of the physician's control, in this respect, are not the only source of frustration and strain. Within these limits, Parsons notes, there is a very important element of *uncertainty*. As in so many practical situations, indeed, the exact nature of the 'known' to the 'unknown' elements bearing on this situation cannot be determined: 'The unknown may operate at any time to invalidate expectations built upon analysis of the known . . .' (1951: 449).

This, Parsons holds, is evident even if one confines one's attention to the 'physiological-biomedical levels of analysis of medical problems' (1951: 449). The general effect of the existence of large factors of known impossibility and of uncertainty, to repeat, imposes strain on the physician, thereby making it more difficult for him (or her) to maintain a 'purely rational' orientation to the job. Professional interactions with patients and their intimates, moreover, add to these strains and underline these non-rational if not irrational elements of medical practice. Non-rational or irrational tendencies, in short, implicate both patients and physicians alike.

Parsons, however, goes further here, suggesting (courtesy of Malinowski among others) that the functional equivalents of 'magic' are frequently found in medical practice: pseudo-science, in his terms, including an 'optimistic bias' on the part of doctors and patients alike, which tend to cluster in situations where there is considerable uncertainty and when there are strong emotional interests in the success of action. 'The health situation', he states, 'is a classic one of the combination of uncertainty and strong emotional interests which produce as situation of strain and is very frequently a prominent focus of magic' (1951: 469). If, from a purely technical point of view both the individual doctor and the general tradition of medical practice are 'optimistically biased', he concludes, 'it ought to help, through a "ritual" demonstration of the will to recover that there *is* a chance' (1951: 469, emphasis in original). This argument, of course, Parsons concedes, cannot be pushed too far. The 'functional needs of society', instead, call for a 'delicate balance in this as in many other fields' (1951: 469).

Again, it is clear, these Parsonian insights speak as powerfully and forcefully to the present (and indeed the future) as they do to the past: the doubts and uncertainties of modernity, in other words, let alone late modernity or postmodernity, have long since been recognized. Fox, for example, in her recent revisiting of medical uncertainty, states that 'as the grounding of medicine shifts in multi-dimensional ways, long-standing sources and manifestations of uncertainty have been reactivated, accentuated or modified, and new ones have been found' (2002: 250). It is, therefore, with: 'extensive

uncertainty about its state of knowledge and accomplishments, its value commitments and its future directions, and with a mixture of confidence and insecurity, that modern medicine faces the twenty-first century' (Fox, 2002: 250). Viewed from this perspective, the uncertainties both Parsons and Fox diagnosed way back in the 1950s have themselves not simply persisted but in many respects worsened or exacerbated in the context of 'rapid scientific and technological, cognitive and ethical, conceptual and empirical, methodological and procedural, social and cultural change' (Fox, 2002: 250). The uncertainties surrounding evidence-based medicine (Sackett et al., 1997) are particularly important to stress in this context; yet another paradox of contemporary medical practice, if not the paradox of paradoxes. Despite being hailed as a 'new paradigm' that helps dispel precisely such uncertainties, evidence-based medicine has in fact 'brought to the surface fundamental epistemological uncertainty about the nature of good clinical research, good clinical practice and the relationship between them' (Fox, 2002: 245). It oversimplifies, moreover, the complexity of the clinical situation, thereby (falsely) claiming certainty where none in fact exists (Fox, 2002: 245; see also Hunter, 1996).

Recourse to Parsonian insights, then, helps us mount a concerted or critical attack not simply on health policies pertaining to the 'expert patient', but also to the (un)certain epistemological foundations of evidence-based-medicine.

Health: late/postmodern Parsons?

It will not have escaped the reader's notice that until now I have said very little about Parsons' treatment of health, as opposed to illness. Parsons, to be sure, like many medical sociologists, said more about the latter than the former. He did not, moreover, explicitly formulate a health role in quite the way he did the sick role. He did, none the less, have some important things to say about health, particularly in the light of American values. Again this is important to stress, given the upsurge of (sociological) interest in *health* matters on the one hand, and the tendency to equate the Parsonian legacy (in the main) with the sick role on the other. This also returns us, of course, full circle, to issues of the body.

Health, for Parsons, is defined as a:

state of optimum *capacity* of an individual for the effective performance of the roles and tasks for which he has been socialized. It is thus defined with reference to the individual's participation in the social system. It is also defined as *relative* to his 'status' in the society, i.e., to differentiated type of role and corresponding task structure, e.g., by sex or age, and by level of education which he has attained and the like. (1964: 274, emphases in original)

It is not therefore, to repeat, a question of *commitment* (to particular roles, tasks, norms or values) here, but of *capacity*, which in turn is *relative*, including qualitative ranges in the differentiation of capacities within various

groups and at given levels of education (Parsons, 1964: 274). These issues, in turn, are further clarified in and through Parsons' deployment of the biologist, Ernst Mayr's, term 'teleonymy' – namely the 'capacity of an organism, or its propensity, to undertake successful goal-oriented courses of behaviour' (Parsons, 1978b: 68). Health, in other words, building on this definition, is to be 'tentatively' (read elaborately) conceived as the:

teleonomic capacity of an individual living organism. The teleonomic capacity that we wish to call health, is the capacity to maintain a favourable self-regulated state that is a prerequisite of the effective performance of an indefinitely wide range of functions both within the system and in relation to its environments . . . Again let it be said that although we accept the focusing of the concept of health at the organic level of the individual, we wish to extend its relevance, on the one hand, into the physical environment and, on the other, into the action environment and the *telic*⁸ system, that is, the psychological and sociocultural environment. (1978b: 69, emphasis added; see also Parsons, 1978c)

There are at least two ways in which these Parsonian insights on health may be taken up, interpreted and addressed in the present context: one perhaps more postmodern than the other, but both none the less putting (healthy) bodies at the heart of the debate.

Shilling (2002), for example, in a recent article, notes how Parsons' analysis of the deep cultural values underpinning western society – rooted as they are in Christian traditions and concerned with maximizing instrumental efficiency – remains highly pertinent to the consumption of health in the contemporary era, not least the emergence of informed, body-conscious people. Parsons' writings, from this stance, are not simply a contribution to current (fashionable) sociological analyses of 'pro-active, "vigilant" approaches towards the healthy body, and the growth of "information rich" consumers of health', but may actually be seen, in an importance sense, as 'anticipating them, as helping to explain their emergence, and as qualifying their relevance to lay behaviour' (Shilling, 2002: 622).

Frank (1991), however, goes further here through his own imaginative (postmodern) reconstruction or resurrection of Parsons. The Parsonian view of health, he ventures, is not so much something that resides 'in' the body, as that which circulates or flows *between* bodies. As a *communicative medium* of exchange, health is based on the *teleonomic* capacity of bodies (described earlier) within an *interactive system*. Health, that is to say, viewed in this light, provides a bridge between any one organic body and its environment: a property of 'neither the body nor the environment, but that which exists between them' (Frank, 1991: 207). To this, Frank suggests, we may add the following:

From Michel Foucault, we add that health is a medium of imposed bodily discipline. From Jean Baudrillard, we question whose teleonomy is involved; thus the second modification is 'teleonomy mediatized'. From Jurgen Habermas, we understand that the nature of health as a medium is to be 'non-discursive'.

Finally, in Pierre Bourdieu we return to Parsons' notion of circulation to suggest health as 'physical capital' . . . These modifications are in no sense discrete from one another, but, as Parsons would be the first to recognize, they interpenetrate. (1991: 207)

Where then does this leave us? Both accounts, to be sure, have their merits, though Shilling perhaps too readily writes off the sick role in favour of the 'information rich consumer of health', while Frank perhaps deconstructs or reconstructs Parsons in ways he may or may not have approved of. Frank's account, none the less, supplements Shilling's in important new ways, adding further important insights and instructive modifications en route. Seen in this light, then, it is not so much a question of choosing between these accounts, but of each highlighting the richness and complexity, if not the ambiguities, of Parsons' work on *health and illness* – which itself, of course, evolved from Chapter X of *The social system* in 1951 to *Action theory and the human condition* in 1978 – and of his abiding importance in these late/postmodern times. Parsons, in short, may very well have been more late or postmodern than many of his critics, or he himself perhaps, realized or cared to admit, not simply in his musings on health, but in all the ways highlighted and discussed throughout this article. At the very least, returning to Shilling, Parsons' work does indeed *anticipate* as well as *qualify* many of these debates.

Conclusions

The conclusions of this article are easy to discern. The Parsonian legacy, I have argued, in keeping with other (recent) sympathetic commentators, is indeed a rich one that lives on, within and beyond the sociology of health and illness. Parsons, of course, is open to criticism on a number of counts, some more valid than others, but his work clearly repays a close re-reading, not simply for past sociological insights into medical practice but for present and future debates in the health (care) arena. His indebtedness to psychoanalytic ideas and insights, likewise, rekindles a profitable dialogue and debate on relations between psychoanalysis and sociology: a case of *appraisal* rather than *praise*, to be sure, but no less important for that.

As far as current debates are concerned, Parsons, as we have seen, has important things to say about the (sick/mortal) body in medical practice, including (ontological) issues of human suffering, frailty and vulnerability, life and death and related matters to do with intimacy and taboo, if not the sacred and the profane. These insights, in turn, are buttressed through some prescient insights into the emotional stresses and strains of the doctor–patient relationship, and the psychodynamics of the medical encounter. Despite his consensual assumptions, moreover, Parsons speaks forcefully and compellingly to the asymmetrical nature of doctor–patient relations, given the expertise of the former and the needs of the latter, and

the importance of trust (active or otherwise) as the binding force for both parties to the encounter. To this, I have added two further Parsonian legacies; the first concerning his seminal insights into the inescapable uncertainties of medical practice, and the functional equivalents of magic in such contexts; the second regarding his embryonic musings on health.

The implications of these issues for current debates on consumerism in health care, and related issues of lay 'expertise' or 'expert patients', are also worth stressing. At the very least, recourse to Parsons demonstrates the danger or limits of much consumerist rhetoric, given our dependence on medicine at the physical, emotional and technical levels, and the unconscious as well as conscious processes at work here in any such medical encounters. Again, I hasten to add, this is not to deny or underplay the active role of the patient, let alone the notion of lay knowledge or embodied expertise, simply to *qualify* it in important ways. The same may be said of other recent policy developments and initiatives such as evidence-based medicine. More radically, perhaps, Parsonian insights into the inescapable problems of uncertainty in medical practice call into question the very wisdom or logic of these initiatives: the epistemological equivalent, one might say, of pissing in the wind.

Whether one wishes to go further here, and turn Parsons into something like a prophet of the late modern condition or (heaven forbid) a closet post-modernist, particularly as far as his views on uncertainty and health are concerned, is of course a moot point. Certainly, as we have seen, it is possible to view or reconstruct Parsons in this light, legitimately or otherwise. To the extent, however, that the present article rekindles interest in Parsons and revives such debates, it will indeed have served its purpose. It may, in this respect, be pertinent to conclude with that old adage, as true today as ever it was: *Plus ça change, plus c'est la même chose!*

Notes

1. The question of whether or not we should be talking here of medical sociology or a more autonomous sociology of health and illness is, of course, an important one. To the extent that Parsons refers to the former, however, I will follow suit in this particular article, broadening the terms of reference to the sociology of health and illness as and when appropriate.
2. I am not, of course, condoning this persistent reference point to doctors as men (i.e. the doc-daddy-default). For every such quoted reference, therefore, please read [*sic*].
3. Parsons' pattern variables may be seen as attempts to resolve a series of fundamental dilemmas that face any actor or social system. To the extent, for example, that I attain my status through training and role performance, that I put collective values over pure self-interest, that I engage with others for instrumental rather than emotional reasons, that I relate to them only for specific restricted purposes and that I judge people according to general criteria rather than those unique to a particular person, then I may be characterized in terms of the following pattern variables: *Achievement*, *Collectivity-orientation*,

Affective-neutrality, Specificity, Universalism. The reciprocal options are *Ascription, Self-orientation, Affectivity, Diffuseness* and *Particularism*. See, for example, Parsons (1951: 46–51, 58–67).

4. Sub-cultures of sickness, of course, from another perspective, stance or viewpoint, may be 'empowering' for the sick.
5. The individual more generally, Parsons' insists,
is a synthesized *combination* of a living organism and a 'personality system', conceived and analysed at the level of 'action' . . . In older terminology he is a combination of a 'body' and a 'mind' . . . In the process of evolution, personalities should be regarded as *emergent* from the organic level, as are cultural systems in a different, though related way. (1978a: 331–2, emphases added)
6. For a more general discussion of the problems of this reason–emotion, rational–irrational division or divide, see Williams (2001).
7. *Projection* involves the psychic process of putting something outside of oneself, into someone else or something; *introjection* to the taking 'in' of something outside oneself, making it part of oneself; while *splitting* involves the splitting of the world into 'good' and 'bad' (Craib, 1988: 146).
8. The term 'telic', Parsons explains in a footnote, while obviously related to teleonomic, is used in the present context to refer to one primary aspect of the human condition, namely that in which 'the problem of culturally and symbolically defined meanings of the human conditions and its various aspects comes to a head'. There is an important sense, in this respect, in which 'the telic environment is cybernetically superordinate to the general system of action and, by virtue of this fact, to the organic level of the organization of living systems as well' (1978b: 69).

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Author biography

SIMON J. WILLIAMS is Reader in Sociology at the University of Warwick. His current research interests centre on developing a sociology of sleep. He has recently completed a book on *Sleep and society: Sociological ventures into the (un)known* (Routledge, in press) and is co-organizer of a new Economic and Social Research Council ‘Sleep and Society’ seminar series (details available at <http://www.warwick.ac.uk/go/sleepandsociety>).